STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT PLACE WEST	55 N MISSION DRIVE INDIANAPOLIS, IN46214

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R0000	This Visit was for State Residential Licensure survey. Survey Dates: April 18, 19, 20, 2011 Facility number: 011840 Provider number: 011840 AIM number: N/A Survey Team: Leia Alley, R.N. TC Marsha Smith, RN Census Bed Type: Residential: 54 Total: 54 Census Payor Type Other: 54 Total: 54 Sample: 7 These State Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on April 26, 2011, by Bev Faulkner, RN	R0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statements of deficiencies. The plan of correction is prepared and submitted because of requirement under state and federal law.Please accept this plan of correction as our credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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R0273	(f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to ensure food prepared for resident consumption was covered to protect from potential contamination. This had the potential of affecting 51 of 51 residents residing in the facility. Findings included: During the initial kitchen tour with the Dietary Manager (DM) on 4/18/11 at 10:45 am, 48	R0273	1. Foods found not covered were disposed of properly. No residents were harmed. 2. All residents have the potential to be affected. All leftover food stored was checked to ensure it was covered and had a label with the "Use By" date. Foods will be covered appropriate until served. 3. The facility policy for storage of leftovers was reviewed with no revisions made. All dietary staff were in-serviced on storage of leftovers and other foods as to prevent potential contamination,(see attachment). The Dietary Manager or designee will complete an audit weekly for 4 weeks then monthly to ensure all foods are stored properly,(see attachment). 4. As a means of quality assurance, the above described monitoring shall be reported to the nurse consultant on a weekly basis. Should concerns be noted, further investigation shall be conducted and disciplinary action and re-education taken as warranted. 5. Completion date April 29, 2011.	04/22/2011

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	bowls of canned mandarin oranges were observed sitting next to resident place settings in the dining room. At this time the DM indicated the bowls of fruit had just been placed on the tables. He indicated the first resident was not served until 11:30 a.m., and the last resident was usually served around 12:30 p.m. During an inspection of the cooler, 10 bowls of jello and 3 bowls of tapioca pudding were observed uncovered. During an interview with the DM at			

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	this time he indicated the food should have been covered.			
R0297	(c) If the facility controls, handles, and administers medications for a resident, the facility shall do the following for that resident: (1) Make arrangements to ensure that pharmaceutical services are available to provide residents with prescribed medications in accordance with applicable laws of Indiana. Based on observation, record review and interview, the facility failed to ensure a medication was provided and administered as prescribed for 1 of 5 residents reviewed for medication administration. The resident involved was Resident #20. Findings Include: During an observation of medication administration on 4/19/11 at 2:00 p.m., Licensed Practical Nurse (LPN) # 1 removed a nebulizer (breathing machine used for inhaled medicines) medication from a box with the following information " Ipratroprium - Albuterol 0.5- 3 mg, generic for Duoneb, use 1 vial per nebulizer 4 times daily". LPN #1 administered this medication to Resident # 20 The Medication Administration Record (MAR) was reviewed on 4/19/11, directly after Resident # 20 received this medication. The MAR indicated that she was to receive "Albuterol 2.5 mg via	R0297	1. Resident #20 was affected. The physician was notified with no further orders. The family was notified. There was no harm to the resident. 2. All residents receiving medications have the potential to be affected. The nurse was re-educated on the medication administration policy and procedure immediately. 3. The facility policy and procedure on medication administration was reviewed with no revisions made. The nurses and QMA's were in-serviced on the medication administration policy and procedure, (see attachment). The DON or designee will complete an audit tool weekly for four weeks then monthly for 11 months to ensure medication administration is completed accurately, (see attachment). 4. As a means of quality assurance, the above described monitoring shall be reported to the nurse consultant on a weekly basis.	04/22/2011

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	nebulizer every 4 hours". During an interview with LPN #1, on 4/19/11 at the time the MAR was reviewed, she indicated that the medication she gave was not the medication that was written, as ordered, on the MAR. LPN #1 then reviewed Resident #20 recent hospital discharge paperwork. The discharge orders were for Resident #20 to receive "Albuterol 2.5 mg via nebulizer every 4 hours". The discharge orders indicated this treatment was to continue while Resident #20 was at the facility. The information had also been transcribed onto the MAR for the facility and sent to the facility's pharmacy. LPN #1 indicated that she was confused because the previous month the resident was taking the Duoneb nebulizer treatments, and that the pharmacy sent a new box of Duoneb nebulizer medication on 4/4/11. Resident #20 returned from a recent hospital stay on 4/1/11. The MAR for the month of March was reviewed on 4/19/11. The MAR for March, 2011 indicated that Resident #20 was taking the Duoneb treatment prior to return from the hospital on 4/1/11. A facility policy, undated, titled "Medication Administration" was reviewed on 4/19/11 at 5:30 p.m. The policy provided information in regards to residents and if they are able or unable to give themselves their own medication, but does not provide information in regards to what would be expected of the staff during medication administration, or what staff should do in case of a medication error.		Should concerns be noted, further investigation shall be conducted and disciplinary action and re-education taken as warranted. 5. Completion date April 29, 2011.	
R0300	(4) Over-the-counter medications, prescription drugs, and biologicals used in the facility must be labeled in accordance with currently accepted professional principles and include the appropriate accessory and cautionary instructions and the expiration date.			

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	Based on observation, record review and interview, the facility failed to ensure over the counter and prescription medications were properly labeled with the inclusion of First Open dates. This affected 5 of 27 residents whose medications were in need of a first open date. (Residents # 1, 5, 33, 38, and 47) Findings Included: During an observation of the first floor medication	R0300	1. Resident #1, 5, 33, 39, 47 were affected. No resident were harmed The ophthalmic and nasal medications were reordered from the pharmacy as needed and the date the medication was opened is documented on the containers. 2. All residents receiving ophthalmic and nasal medications have the potential to be affected. Administrative nurse has completed an audit on all stored medications to ensure medications are properly labeled with the date opened as indicated and there no expired medications. 3. The facility policy for medication storage was reviewed with no revisions made. Nurses and QMA's were in-serviced on medication storage, (see attachment). The DON or designee will complete an audit tool weekly for 4 weeks, then monthly for 11 months to ensure medications are labeled with the date open,(see attachment). 4. As a means of quality assurance, the above described monitoring shall be reported to the nurse consultant on a weekly basis. Should concerns be noted, further investigation shall be conducted and disciplinary action and re-education taken as warranted. 5. Completion date April 29, 2011.	04/22/2011

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	cart on 4/20/11 at 10:20 a.m. and in the presence of LPN #1, one opened bottle of eye drops, and one opened bottle of nose spray were reviewed for a date in which they were opened and given to a resident. The bottles belonged to the following residents: Resident #1 and Resident #5. These medications were without first opened dates. During an interview with LPN #1 at the time of the first floor medication			

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	cart observation, she confirmed that the two medications observed were without open dates. During an observation of the second floor medication cart on 4/20/11 at 10:45 a.m. and in the presence of LPN #2, five opened bottles of eye drops were reviewed for a date in which they were opened and given to a resident. The bottles belonged to the following residents: Resident #33, Resident #38 and Resident #47. These medications were			

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	without first opened dates. During an interview with LPN #2, at the time of the second floor medication cart observation, she confirmed that the five medications observed were without open dates. An undated facility policy, titled "Medication Administration" was reviewed on 4/19/11 at 4: 30 p.m. The policy did not provide any information in regards to			

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	dating medication once it had been opened.			
R0352	(e) The clinical record must contain the following: (1) Sufficient information to identify the resident. (2) A record of the resident ' s evaluations. (3) Services provided. (4) Progress notes. Based on record review and interview, the facility failed to ensure laboratory specimens ordered by the physician and the results of these tests were obtained in a timely manner for 2 of 5 residents reviewed for having labs drawn and timely results obtained in a sample of 7. (Residents #22 and #1) Findings included: 1. The record of Resident #22 was reviewed on 4/18/11 at 3:00 p.m.. Diagnoses for Resident #22 included, but were not limited to, diabetes mellitus, urinary incontinence and urinary tract infection. A physician's order, dated 3/3/11, indicated the resident was to have a urine specimen obtained for a Urinalysis with	R0352	1. Resident #22 and 1 were affected. The residents were placed on antibiotics as ordered to treat the infections and were not harmed. 2. All residents with laboratory orders have the potential to be affected. All current laboratory orders reviewed to ensure the specimen is obtained timely and orders obtained to address results as appropriate. 3. The facility policy for following physicians orders was reviewed with no revisions made. All nurses and QMA's were in-serviced on following physicians' orders and obtaining laboratory specimens and addressing results timely,(see attachment). The DON or designee will complete an audit tool weekly for 4 weeks, then monthly for 11 months to ensure laboratory specimens are obtained and results addressed timely. 4. As a means of quality assurance, the above described monitoring shall be reported to	04/22/2011

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	Culture and Sensitivity. (UA C & S) A lab report with the results of the UA C& S indicated the specimen was not obtained until 3/10/11 with final results reported on 3/12/11. A nurse's note dated 3/14/11 indicated an antibiotic had been started due to the resident having a urinary tract infection. Further information was requested from the Director of Nursing (DON) on 4/18/11 at 4:30 p.m., regarding why the specimen was ordered on 3/3/11 and not obtained until 3/10/11. On 4/19/11 at 3:00 p.m., the DON indicated he did not know why the specimen was not obtained sooner. He indicated there were some resident behaviors documented on 3/4/11, 3/6/11, and 3/9/11 but he could not find any documentation to indicate the nursing staff had attempted to obtain the urine specimen prior to 3/10/11. 2. The record for Resident #1 was reviewed on 4/18/11 at 3:45 p.m. Diagnoses for Resident #1 included, but were not limited to, anemia, GERD, COPD (chronic obstructive pulmonary disease), hypothyroidism, and anxiety		the nurse consultant on a weekly basis. Should concerns be noted, further investigation shall be conducted and disciplinary action and re-education taken as warranted. 5. Completion date April 29, 2011.	

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	related to COPD. A physician's order, dated 3/25/11, indicated the resident was to have a gram stain and culture respiratory sputum (microscopic view of bacteria found in phlegm). A lab report, dated 3/31/11, indicated that the sputum culture was contaminated with Diptheroid rod shaped bacteria. Antibiotic therapy was ordered for Resident #1 on 4/12/11. Further information was requested from the DON on 4/19/11 at 4 p.m. There was no further information provided by the DON in regards to why it took 12 days for Resident #1 to start antibiotic treatment. An interview on 4/19/11 at 3:00 p.m., the DON indicated that it is nursing's job to report laboratory findings to the residents physician. The DON indicated that there is no designated staff person to follow up on laboratory findings once they have been called or faxed into the physician.			